BRiMS Study daily diary – to be returned in the FREEPOST envelope provided.

Please send us one of these diaries every two weeks

Participant Number: 1001

Instructions:

1. Enter the date of the first day of this diary and which day of the week you start in the spaces provided.
2. For each day, please write down the number of falls you have (if any) and the number of falls that cause any injury.
3. If you don't have a fall that day please enter '0' rather than leaving the box blank.

Start *Day* of Diary: _____day *(Monday, Tuesday etc)*

Start *Date* of Diary: D D M M M Y Y Y Y

Please consider a fall as "an unexpected event in which you come to rest on the ground, floor, or lower level".

Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day of week (initial only: M, T, W, Th, F, Sa, Su)							
Number of falls							
Number of falls that caused you injury							
Week 2	**Day 1**	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**
Day of week (initial only: M, T, W, Th, F, Sa, Su)							
Number of falls							
Number of falls that caused you injury							

At the end of the two weeks please answer the questions on the following pages:

Participant Number: **«Participant_Number»**

If you have not had any falls, please go directly to question 5

1. Please write down the number of each **type** of injury as a result of any fall:

No injuries in this two week period (tick) ☐

	Head	Body	Arms	Legs
Bruises				
Cuts/scrapes				
Sprain/Strain				
Dislocation				
Broken Bone				

2. Did you use any of the following medical or other services because of any falls?

No ☐ **Yes** ☐ **Not applicable** ☐

If YES, please complete this chart:

Medical Service or Other Care	**Number of times**
Nurse visit	
GP practice visit	
Specialist doctor visit (hospital or privately) What type of specialist?	
Emergency Department	
Admission to hospital How many days were you hospitalized?	
Other (please state)	

3. Did you lay on the ground or floor for more than 10 minutes because of any falls?

No ☐ **Yes** ☐ **Not applicable** ☐

If YES, please complete this chart:

Time on the ground or floor	**Number of times**
Between 10 and 30 minutes	
Between 30 and 60 minutes	
For more than 60 minutes	

Please Turn over and continue ….

4. Did you need help to get up after any falls?

No ☐ **Yes** ☐ **Not applicable** ☐

If YES, please complete this chart:

Help provided by:	**Number of times**
Family member	
Friend or neighbour	
Healthcare Professional (e.g. paramedic)	

5. Have you experienced any new or worsening problems (e.g. pain, fatigue, anxiety) related to activities or exercise that you have undertaken in this two-week period?

No ☐ **Yes** ☐

If YES, please complete this chart:

Problem	**Please tell us if you felt it was Mild, Moderate or Severe**	**Duration (how long did it last for?**

6. Have you had any MS relapses in the last two weeks?

No ☐ **Yes** ☐

A relapse is defined as: "**the appearance of new symptoms, or the return of old symptoms, for a period of 24 hours or more – in the absence of a change in core body temperature or infection**"

If YES, please complete the following:

When did the relapse start?	
How long did it continue?	
What symptoms did you notice?	
Did you consult a healthcare professional?	**No** ☐ **Yes** ☐
If Yes, which healthcare professional did you see?	
What treatment did you have?	